TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

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Article 6, consisting of Section R9-27-601, repealed by final rulemaking at 10 A.A.R. 817, effective April 3, 2004. The subject matter of Article 6 is now in 9 A.A.C. 34 (Supp. 04-1).

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ARTICLE 1. DEFINITIONS

R9-27-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"ADHS"	R9-27-101
"AHCCCS"	R9-27-101
"Administrative law judge"	A.R.S. § 41-1092
"Adverse action"	R9-27-101
"Administrative review"	R9-27-101
"Ambulance"	A.R.S. § 36-2201
"Certification"	29 U.S.C. 1181
"Clean claim"	A.R.S. § 36-2904
"Coinsurance"	R9-27-101
"Complainant"	R9-27-101
"Copayment"	R9-27-101
"Covered services"	R9-27-101
"Creditable coverage"	A.R.S. § 36-2912
"Date of notice"	R9-27-101
"Day"	R9-27-101
"Deductible"	R9-27-101
"Dependent"	R9-27-101
"Durable medical equipment" or "DME"	R9-27-101
"Eligible employee"	A.R.S. § 36-2912
"Emergency ambulance service"	R9-27-101
"Emergency medical services"	R9-27-101

"Employee member"	R9-27-101
"Employer group"	R9-27-101
"Enrollment"	R9-27-101
"Experimental Services"	R9-22-101
"Full-time employee"	R9-27-101
"Grievance"	R9-27-101
"Group Service Agreement" or "GSA"	R9-27-101
"Healthcare Group Administration" or "HCGA"	R9-27-101
"HCG"	R9-27-101
"HCG Plan"	R9-27-101
"Health care practitioner"	R9-27-101
"Hearing"	R9-27-101
"Hospital"	R9-27-101
"Inpatient hospital services"	R9-27-101
"Late enrollee"	A.R.S. § 36-2912
"Life threatening"	R9-27-101
"Medical record"	R9-27-101
"Medical services"	A.R.S. § 36-401
"Medically necessary"	R9-27-101
"Member"	R9-27-101
"Noncontracting provider"	R9-27-101
"Office of Administrative Hearings" or "OAH"	A.R.S. § 41-1092
"Outpatient service"	R9-27-101
"Party"	R9-27-101
"Pharmaceutical service"	R9-27-101
"Physician service"	R9-27-101
"Political subdivision"	R9-27-101
"Pre-existing condition"	A.R.S. § 36-2912
"Pre-existing condition exclusion"	A.R.S. § 36-2912
"Premium"	R9-27-101
"Pre-payment"	R9-27-101
"Prescription"	R9-27-101
"Primary care practitioner"	R9-27-101
"Primary care provider"	R9-27-101
"Prior authorization"	R9-27-101
"Quality management"	R9-27-101
"Referral"	R9-27-101
"Respondent"	R9-27-101
"Scope of services"	R9-27-101
"Service area"	R9-27-101
"Spouse"	R9-27-101
"Subcontract"	R9-27-101
"Utilization control"	R9-27-101
"Utilization review"	R9-27-101
"Waiting period"	A.R.S. § 36-2912

B. Definitions. In addition to the definitions contained in A.R.S. Title 36, Chapter 29, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"ADHS" means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible member.

"Adverse action" means any action under this Chapter, including adverse eligibility actions, for which a party may file a grievance or request a hearing under A.R.S. § 41-1092 et seq. under 9 A.A.C. 27, Article 6.

"Administrative review" means that portion of the grievance process beginning with the filing of a grievance with the Administration or its contractor and concluding with the issuance of a final decision by the Administration or its contractor that advises the party of formal hearing rights under A.R.S. § 41-1092 et seq.

"Coinsurance" means a predetermined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.

"Complainant" means an applicant, member, person, or entity filing a grievance or request for hearing.

"Copayment" means a monetary amount specified by the HCGA that a member or dependent pays directly to a provider at the time a covered service is rendered.

"Covered services" means the health and medical services described in 9 A.A.C. 27, Article 2.

"Date of notice" means the date on a notice of action.

"Day" means a calendar day unless otherwise specified in the text.

"Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the HCG Plan agrees to pay.

"Dependent" means the eligible spouse and children of an employee member under 9 A.A.C. 27, Article 3.

"Durable Medical Equipment" or "DME" means durable items or appliances, as determined by the HCG Plan to be a medically necessary item or supply and a benefit under the Employer's GSA. The DME is:

Able to withstand repeated use;

Designed to serve a medical purpose;

Generally not useful to a person in the absence of a medical condition, illness, or injury;

Not customarily found in a physician's office;

Is not disposable; and

Is needed for functional rather than cosmetic reasons.

"Emergency ambulance service" means:

Transportation by an ambulance or air ambulance company for a member requiring emergency medical services.

Emergency medical services that are provided by a person certified by the ADHS to provide the services before, during, or after a member is transported by an ambulance or air ambulance company.

"Emergency medical services" means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

Placing a patient's health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ.

"Employer group" means the aggregate enrollment of an employer group or business with a HCG Plan for covered services.

"Employee member" means an enrolled employee of an employer group.

"Enrollment" means the process by which an applicant applies for coverage under an employer group contracted with HCGA.

"Full-time employee" means an employee who works at least 20 hours per week and expects to continue employment for at least five months following enrollment.

"Grievance" means a complaint that initiates an administrative review that does not involve a hearing under A.R.S. § 41-1092 et seq. A party may request a hearing under A.R.S. § 41-1092 et seq. after an administrative review.

"GSA" means Group Service Agreement, a contract between an employer group and HCGA.

"Healthcare Group Administration" or "HCGA" means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG Program.

"HCG" means Healthcare Group of Arizona, the registered name of the Healthcare Group Program, a prepaid medical coverage product marketed by the HCGA to small uninsured businesses and political subdivisions within the state.

"HCG Plan" means a Healthcare Group prepaid health plan that is currently under contract with the HCGA to provide covered services to a member of an employer group.

"Health care practitioner" means a:

Physician,

Physician assistant,

Nurse practitioner; or

Other person who is licensed or certified under Arizona law to deliver health care services.

"Hearing" means an administrative hearing under Title 41, Chapter 6, Article 10.

"Hospital" means a health care institution licensed as a hospital by the ADHS under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.

"Inpatient hospital services" means a medically necessary service that requires an inpatient stay in an acute care hospital. An inpatient hospital service is provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

"Life threatening" means any condition for which a delay in obtaining pre-authorization or traveling to an approved medical facility would have a severe adverse effect on a patient's condition.

"Medical record" means a single, complete record kept at the site of a member's primary care provider that documents the medical services received by a member, including inpatient discharge summary, outpatient care, and emergency care.

"Medically necessary" means covered services provided by a physician or other health care practitioner within the scope of the physician's or other health care practitioner's practice under state law to:

Prevent disease, disability, and other adverse health condition or its progression; or

Prolong life.

"Member" means an employee or a dependent who is enrolled with an HCG Plan.

"Noncontracting provider" means a provider who renders covered services to a member but who does not have a subcontract with the member's HCG Plan.

"Outpatient service" means a medically necessary service that may be provided in any setting on an outpatient basis that does not require an overnight stay in an inpatient hospital. An outpatient service is provided by or under the direction of a physician or other health care practitioner, upon referral from a member's primary care provider.

"Party" means a person or entity by or against whom a grievance or request for hearing is brought.

"Pharmaceutical service" means a medically necessary medication prescribed by a physician, a practitioner, or a dentist upon referral by a primary care provider and dispensed under 9 A.A.C. 27, Article 2.

"Physician service" means a service provided within the scope of practice of medicine or osteopathy as defined by state law, by, or under the direction of a person licensed under state law to practice medicine or osteopathy.

"Political subdivision" means the state of Arizona, a county, a city, a town, or a school district within the state.

"Premium" means the monthly pre-payment submitted to HCGA by the employer group.

"Pre-payment" means submission of the employer group's premium payment 30 days in advance of the effective date of coverage under 9 A.A.C. 27, Article 3.

"Prescription" means an order for covered services for a member that is signed or transmitted by a provider licensed under applicable state law to prescribe or order the service.

"Primary care practitioner" means a physician assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.

"Primary care provider" means a member's primary care physician or a primary care practitioner.

"Prior authorization" means the process by which the HCG Plan authorizes, in advance, the delivery of a covered service.

"Quality management" means a methodology used by professional health personnel to assess the degree of conformance to desired medical standards and practices and to implement activities designed to continuously improve and maintain quality service and care, and which is performed through a formal program with involvement of multiple organizational components and committees.

"Referral" means the process by which a primary care provider directs a member to another appropriate provider or resource for diagnosis or treatment.

"Respondent" means a party responsible for the adverse action that is the subject of a grievance or request for hearing.

"Scope of services" means the covered, limited, and excluded services listed in 9 A.A.C. 27, Article 2.

"Service area" means the geographic area designated by HCGA where each HCG Plan shall provide covered health care benefits to members directly or through subcontracts.

"Spouse" means a husband or a wife of an HCG member who has entered into a marriage recognized as valid by Arizona.

"Subcontract" means an agreement entered into by an HCG Plan with any of the following:

A provider of health care services who agrees to furnish covered services to members,

A marketing organization, or

Any other organization to serve the needs of the HCG Plan.

"Utilization control" means an overall accountability program encompassing quality management and utilization review.

"Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective April 30, 1992 (Supp. 92-2). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. Scope of Services

A. HCGA shall provide a list of covered services to each HCG Health Plan. Each HCG Plan shall provide, either directly or through subcontracts, a list of the covered services specified in this Article.

B. Provision of covered services. The HCG Plans shall ensure that covered services are provided by, or under the direction of, a primary care provider.

C. Scope of covered services. An HCG Plan shall not further delineate, expand, or limit the list of covered services beyond the standard covered services under this Article or GSA.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-202. Covered Services

Covered services. Subject to the exclusions and limitations specified in these rules and the GSA, an HCG Plan shall cover the following services:

1. Outpatient services;
2. Laboratory, radiology, and medical imaging services;
3. Prescription drugs;
4. Inpatient hospital services;
5. Emergency medical services under R9-27-209 in and out of the service area;
6. Emergency ambulance services;
7. Maternity care;
8. Cornea transplants;
9. Kidney transplants;
10. Durable medical equipment, orthotics, and prostheses as specified in the GSA; and
11. Other services as agreed under the GSA.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-203. Exclusions and Limitations

A. Excluded medical services. Any medical service not specifically provided for in this Article is not a covered medical service.

B. Excluded services. An HCG Plan shall not cover the following:

1. Services or items furnished solely for cosmetic purposes except for breast reconstruction performed by an HCG Plan following a mastectomy, and services or items provided to reconstruct or improve personal appearance after an illness or injury as specified in the GSA;
2. Services or items requiring prior authorization for which prior authorization has not been obtained;
3. Services or items furnished gratuitously or for which charges are not usually made;
4. Hearing aids, eye examinations for prescriptive lenses, prescriptive lenses and surgery for the correction of myopia;
5. Long-term care services, including nursing services;
6. Private or special duty nursing services, provided in a hospital unless medically necessary and prior authorized by the HCG Plan Medical Director.
7. Care for health conditions that are required by state or local law to be treated in a public facility;
8. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are reasonably available;
9. Gastric stapling or diversion for weight loss;
10. Reports, evaluations, or physical examinations not required for health reasons including employment, insurance, or governmental licenses, sports, and court-ordered forensic or custodial evaluations;
11. Treatment of temporomandibular joint dysfunction, unless treatment is prior authorized and determined medically necessary by the HCG Plan Medical Director or designee;
12. Pregnancy termination under A.R.S. § 35-196.02;
13. Medical and hospital care and costs for the child of a dependent, unless the child is otherwise eligible under the GSA;
14. Nonmedical ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning disabilities;
15. Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);
16. Services not deemed medically necessary by the HCG Plan Medical Director, or the responsible primary care provider;
17. Routine foot care;
18. Blood products, blood derivatives, synthetic blood, including artificial and genetic derivatives and coagulation factors and the associated charges for the administrative costs which are separately billed;
19. Organ transplants except as specified in R9-27-202;
20. Bone marrow transplants including autologous, allogeneic-related, and allogeneic-unrelated;
21. Mental health services;
22. Acupuncture;
23. Dental services;
24. Transportation other than emergency ambulance services;
25. Psychotherapeutic drugs;
26. Charges for injuries incurred as the result of:
    a. Participating in a riot;

b. Committing, or attempting to commit a felony or assault;
c. Committing intentional acts of self inflicted injuries; or
d. Attempting suicide.

27. Infertility testing, in vitro fertilization and all other fertilization treatments;
28. Allergy testing and hyposensitization treatment;
29. Experimental services as determined by the HCGA, or services provided primarily for the purpose of research;
30. Alternative medicine;
31. Chiropractic services;
32. Osteopathic manipulation therapy; and
33. Other services under the GSA.

C. Limitations. When providing covered services, the HCG Plan shall adhere to the coverage limitations in this Article, the GSA, and the following:

1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when a patient must be isolated for medical reasons.
2. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary as determined by the HCG Plan Medical Director, or designee.
3. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
4. Hospice services are limited to the terms in the GSA.
5. Home infusion therapy is limited to the terms in the GSA.
6. Home Health Care is limited to the terms in the GSA.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective April 30, 1992 (Supp. 92-2). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-204. Out-of-service Area Coverage

Out-of-service area coverage. As specified in R9-27-209, a member is entitled to only emergency services when outside the member's HCG Plan service area. The Administration shall not cover services outside the United States.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-205. Outpatient Health Services

Outpatient services. The HCG Plan shall provide the following covered services if medically necessary:

1. Ambulatory surgery and anesthesiology services not specifically excluded;
2. Physician's services;
3. Pharmaceutical services and prescribed drugs to the extent authorized in this Article and under the GSA;
4. Laboratory services;
5. Radiology and medical imaging services;
6. Services of other health care practitioners when supervised by a physician;
7. Nursing services provided in an outpatient health care facility;
8. The use of emergency, examining, or treatment rooms when required for the provision of physician services;
9. Specialty care physician services referred by a primary care provider or health plan;
10. Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic work-ups that include treatments or procedures to:
    a. Determine risk of disease,
    b. Provide early detection of disease,
    c. Detect the presence of injury or disease at any stage,
    d. Establish a treatment plan for injury or disease at any stage,
    e. Evaluate the results or progress of a treatment plan or treatment decision, or
    f. Establish the presence and characteristics of a physical disability that may be the result of disease or injury.
11. Short-term rehabilitation is provided as specified in the GSA, if in the judgment of the HCG Plan Medical Director or designee, the treatment can be expected to result in the significant improvement of a member's condition.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-206. Laboratory, Radiology, and Medical Imaging Services

A. Coverage of medically necessary laboratory, radiology, and medical imaging services. Medically necessary laboratory, radiology, and medical imaging services shall be provided by a licensed or certified health care provider as prescribed by the member's primary care provider. These services shall be provided through the HCG Plan in a hospital, a clinic, a physician's office or other health facility.

B. Satisfaction of applicable license and certification requirements. A clinical laboratory, radiology, or medical imaging service provider must satisfy all applicable state and federal license and certification requirements and shall provide only services that are within the categories stated in the provider's license or certification.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-207. Pharmaceutical Services

A. Provision of pharmaceutical services. The HCG Plan shall ensure that pharmaceutical services are available to members during customary business hours. The services shall be located within reasonable travel distance as determined by the HCGA within the HCG Plan's service area.

B. Limitations. The HCG Plan shall adhere to the following limitations when providing a pharmaceutical service:

1. Drugs personally dispensed by a physician or a dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. Prescription drugs are prescribed up to a 30-day supply unless the HCG Plan determines a longer supply is more cost-effective.
3. Members are eligible for immunosuppressant drugs only as part of the post-operative treatment for a covered kidney or cornea transplant authorized by an HCG Plan as specified in R9-27-202.

4. Over-the-counter drugs are not covered.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-208. Inpatient Hospital Services

A. Inpatient hospital services. The HCG Plan shall provide the following inpatient hospital covered services if medically necessary:
1. Routine services, including:
   a. Hospital accommodations;
   b. Specialty units;
   c. Nursing services necessary and appropriate for a member's medical condition;
   d. Dietary services;
   e. Medical supplies, appliances, and equipment furnished to hospital inpatients, billed as part of routine services, and included in the daily room and board charge;
2. Ancillary services, including:
   a. Labor, delivery and recovery rooms, and birthing centers;
   b. Surgery and recovery rooms;
   c. Laboratory services;
   d. Radiological and medical imaging services;
   e. Anesthesiology services;
   f. Rehabilitation services as specified in the GSA;
   g. Pharmaceutical services and prescribed drugs;
   h. Respiratory therapy;
   i. Maternity services;
   j. Nursery and related services;
   k. Chemotherapy; and
   l. Dialysis as limited in this Article.

B. Limitations. The HCG Plan shall adhere to the following coverage limitations when providing inpatient hospital services:
1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when a patient must be isolated for medical reasons.
2. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
3. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary as determined by the HCG Plan Medical Director, or designee.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-209. Emergency Medical Services

A. Emergency medical services provided within the HCG Plan's service area.
1. Emergency medical services shall be provided to a member 24 hours-a-day, seven days-a-week based on the prudent layperson standard under 42 U.S.C. 1396u-2.
2. The member or provider shall notify the HCG Plan no later than 24 hours after the initiation of treatment.
3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 24 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.

B. Emergency medical services provided outside the HCG Plan's service area.
1. Emergency medical services provided outside the HCG Plan's service area is based on the prudent layperson standard under 42 U.S.C. 1396u-2.
2. The member or provider shall notify the HCG Plan no later than 48 hours after the initiation of treatment.
3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 48 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.

C. Ambulance services.
1. Within the HCG Plan's service area. A member is entitled to emergency ambulance services within the HCG Plan's service area. The provider shall notify the HCG Plan within 10 working days after providing emergency ambulance service to the member. Failure to provide notice within 10 working days constitutes cause for denial of payment.
2. Outside the HCG Plan's service area. A member is entitled to ambulance services outside the HCG Plan's service area to transport the member to the nearest medical facility capable of providing necessary emergency services. The provider shall notify the HCG Plan within 10 working days after providing emergency ambulance service to the member. Failure to provide notice within 10 working days constitutes cause for denial of payment.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-210. Pre-existing Conditions

A. Pre-existing conditions exclusions. Subject to subsection (B), an HCG Plan shall not cover any services related to a pre-existing condition as specified in A.R.S. § 36-2912.

B. Failure to impose a pre-existing condition exclusion. An HCG Plan shall not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:
1. Newborns from the time of birth if enrolled within the time-frames under R9-27-308;
2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308:
   a. A person who had continuous coverage for a one-year period and during that year had no breaks in coverage totaling more than 31 days; and
   b. A person's prior coverage ended within 63 days before the date of enrollment.

C. Credit for prior health coverage. An HCG Plan shall apply a credit toward meeting the 12 month pre-existing condition exclusion of one month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan under A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan that provided continuous coverage to an individual shall disclose the coverage provided.

D. Late enrollee pre-existing conditions time-frames. An HCG Plan shall exclude coverage for a preexisting condition for a late enrollee under A.R.S. § 36-2912 as follows:
1. For 12 months if the member enrolls within 30 days of the designated enrollment time-frame, or

2. For 18 months if the member enrolls 31 or more days after the designated time-frame for enrollment.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective October 12, 1988 (Supp. 88-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-211. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Repealed effective July 15, 1997 (Supp. 97-3).

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for Employer Groups

A. Criteria for employer groups.
1. An employer group shall conduct business:
   a. Within Arizona for at least 60 days before making application to be an employer group eligible for HCG coverage; and
   b. Within a county which has an HCG Plan.
2. The HCGA shall determine eligibility for an employer group and its employees through documentation of one or more of the following:
   a. Participation in state unemployment insurance;
   b. Participation in state worker's compensation;
   c. Personal tax return with schedule C, SE, or SEZ; or
   d. Other verifiable proof that the applicant is conducting a business in Arizona.

B. Amount of eligible employees and enrollment. Other than the state of Arizona and political subdivisions of the state, an employer group shall have a minimum of one and a maximum of 50 eligible employees at the effective date of the first GSA with HCGA. Acceptable proof of the number of eligible employees may include canceled checks, bookkeeping records, and personnel records.

C. Required enrollment of a particular number of employees. Other than state employees and employees of political subdivisions of the state, employers with one to 50 eligible employees may contract with HCGA if the employer:
1. Has five or fewer eligible employees and enrolls 100% of these employees in an HCG Plan, or
2. Has six or more eligible employees and enrolls 80% of these employees in an HCG Plan.

D. HCGA does not include employees who work less than 20 hours per week when determining participation requirements.

E. Employees with proof of other insurance. Employees with proof of existing health care coverage who elect not to participate in an HCG Plan shall not be considered when determining the percentage of the required number of enrollees if the health care coverage is:
1. Group coverage offered through a spouse, a parent, or a legal guardian; or
2. Coverage available from a government-subsidized health care program.

F. Post-enrollment changes in group size. Changes in group size that occur during the term of the GSA shall not affect eligibility.

G. Review and verification of eligibility determinations. The HCGA may conduct random reviews of eligibility determinations of an employer group and its employees.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended subsection (C) effective October 12, 1988 (Supp. 88-4). Amended effective March 31, 1992 (Supp. 92-1). Amended effective April 30, 1992 (Supp. 92-2). Amended effective September 13, 1993 (Supp. 93-3). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-302. Eligibility Criteria for Employee Members

A. Residence. An employee member shall reside, work, or reside and work in Arizona and in a county with an HCG Plan.

B. Eligible employer group. An employee member shall be employed by an eligible employer group specified in R9-27-301.

C. Days of consecutive employment. An employee member shall have been employed at least 60 consecutive days before the effective date of coverage.

D. Hours of employment per week. A member working for an employer group or a self-employed person shall work at least 20 hours per week, with anticipated employment of at least five months following enrollment.

E. Eligibility for government subsidized health care programs. The HCGA shall provide written information to members who may be eligible for a government subsidized health care program.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-303. Eligibility Criteria for Dependents

A. Eligible dependents. An eligible dependent of an employee member shall reside in Arizona, in a county with an HCG Plan and includes:
1. A legal spouse;
2. Unmarried children less than the age of 19 or less than the age of 24 if the child is a full-time student and is:
   a. A natural child,
   b. An adopted child,
   c. A step-child, or
   d. A child for whom the employee member is a legal guardian.
3. A child incapable of self-sustaining support by reason of mental or physical disability existing before the child's 19th birthday, as determined by the HCG Plan Medical Director or designee.

B. Limitations. A grandchild of an employee member shall be eligible to receive covered services only if the grandchild meets the eligibility requirements in subsection (A)(2)(b), (c), and (d) or (A)(3).

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-304. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Section repealed by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-305. Health History Form

Completion of a health history form. An eligible employee and dependents shall complete the HCG health history form before enrollment. An eligible employee or a dependent shall not be denied enrollment as a result of conditions described on the health history form. Pre-existing conditions limit the benefits available to a member as specified in R9-27-210. Failure to provide complete and accurate information on the health history form is cause for immediate termination from the HCG Plan.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-306. Effective Date of Coverage

A. Payment in advance of effective date. Employer groups shall submit payment 30 days in advance of the effective date of coverage. If the Administration receives the full premium payment on or before the 15th day of the month, enrollment will begin on the first day of the next month. If the Administration receives the full premium payment after the 15th day of the month, coverage begins on the first day of the second month. No retroactive coverage is available.

B. Other effective date options. For other effective date options, an employer group shall complete and submit the enrollment documents and initial premium payment by the time-frames specified in the GSA.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-307. Open Enrollment of Members

A. Open enrollment. Enrollment of an employee member shall occur only during one of the following open enrollment periods:
1. Thirty days following the effective date of the GSA for a newly enrolled employer group;
2. A 31-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a 31-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever period is greater; or
3. A 31-day period to begin 105 days before and conclude at least 75 days before the employer group's renewal date, as determined by the HCGA.

B. New dependent enrollment. Enrollment of new dependents shall occur:
1. Within the 31-day period following the addition of a new dependent defined in R9-27-303(A), or
2. Under R9-27-308 if the dependent is a newborn.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective April 30, 1992 (Supp. 92-2). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-308. Enrollment of Newborns

Newborn enrollment. A newborn shall be enrolled 30 days following the birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA 30 days following the birth for coverage retroactive to the first day of the month in which the birth occurred.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-309. Enrollment of Newly Eligible Employee and Dependent Due to Loss of Own Coverage

A. Enrollment of newly eligible employee due to loss of own coverage. An eligible employee who had health care coverage through a spouse is eligible to enroll as a member within 30 days of the loss of coverage, if that loss of separate health care coverage is due to:
1. Death of the eligible employee's spouse,
2. Divorce,
3. Termination of employment of the eligible employee's spouse,
4. Legal separation, or
5. Reduction in hours of employment.

B. Enrollment of newly eligible dependent due to loss of own coverage. An eligible dependent, who had individual or family health care coverage separate from the member's coverage is eligible to enroll as a dependent member within 30 days of the loss of coverage, if that loss of separate health care coverage is due to:
1. Death,
2. Divorce,
3. Termination of employment,
4. Legal separation,
5. Reduction in hours of employment, or
6. Retirement.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-310. Denial and Termination of Enrollment

A. Denial of enrollment. An employer group, an employee, or a dependent who fails to meet the requirements of this Article shall be denied enrollment.

B. Termination of enrollment. Termination of enrollment and coverage for an employer group, an employee member, or a dependent shall occur on the last day of the month that:
1. The employer group loses eligibility,
2. The employee member loses eligibility, or
3. The dependent loses eligibility.

C. Exclusion from enrollment. The HCGA may exclude an employer group or an employee member from enrollment who has committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

ARTICLE 4. CONTRACTS AND GSAS

R9-27-401. General

A. Contracts to provide services. The HCGA shall establish contracts to provide services with qualified HCG Plans under A.R.S. § 36-2912.

B. GSAs with employer groups. The HCGA shall establish GSAs with employer groups under A.R.S. § 36-2912.

C. Contracts and GSAs. Contracts and GSAs entered into under A.R.S. § 36-2912 and on file with the HCGA are public records unless otherwise made confidential by law.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-402. Contracts and GSAs

A. Requirements for a health plan. A health plan shall meet the requirements of A.R.S. § 36-2912 and all HCGA contract requirements.

B. Requirements for an employer group. An employer group shall meet the requirements of A.R.S. § 36-2912 and all GSA requirements.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-403. Repealed

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Section repealed by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-404. Repealed

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Section repealed by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-405. Contract And GSA Termination

A. Contract between the HCGA and an HCG Plan. Under this Article and as specified in contract, the HCGA may suspend, deny, refuse, fail to renew, or terminate a contract or require the HCG Plan to terminate a subcontract for good cause which may include the following reasons:

1. Submission of any misleading, false, or fraudulent information;
2. Provision of any services in violation of or not authorized by licensure, certification, or other law;
3. A material breach of contract;
4. Failure to provide and maintain quality health care services to members, as determined by standards established by the state; and
5. Failure to reimburse a medical provider within 60 days of receipt of a clean claim unless a different period is specified by contract.

B. Group Service Agreement between the HCGA and an employer group. The GSA may be terminated with written notice from either the HCGA or an employer group to the other party within time-frames specified in the GSA.

C. Termination of a member by the HCGA or HCG Plan.

1. Cause for immediate termination of coverage. The HCGA or HCG Plan may terminate a member's coverage for the following:
   a. Fraud or misrepresentation when applying for coverage or obtaining services; or
   b. Violence, or threatening or other substantially abusive behavior toward the HCGA or the HCG Plan employees or agents, or contracting or noncontracting providers or their employees or agents.
2. Cause for termination with 30 days written notice. The HCGA or the HCG Plan may terminate coverage of a member for the following reasons:
   a. Repeated and unreasonable demands for unnecessary medical services;
   b. Failure to pay any copayment, coinsurance, deductible, or required financial obligation; and
   c. Material violation of any provision of the GSA.
3. Termination by reason of ineligibility.
   a. Termination of employment;
   b. Failure of employer to pay premium. Termination shall be effective the first day of the month for which the premium has not been paid;
   c. Coverage of a dependent member shall automatically cease on the last day of the month in which the dependent member loses coverage, for any reason described in R9-27-406.
   d. Subject to continuation coverage, as described in R9-27-406, on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to a member whose coverage has been terminated; except that a member confined to a hospital at the effective date of termination shall continue to receive coverage until there has been a determination by the HCG Plan Medical Director or designee that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital; and
   e. An employee member whose coverage terminates according to this subsection shall not be eligible for re-enrollment until the employer group's next open enrollment period. The employee shall meet all the eligibility criteria prescribed by these rules before re-enrollment.

D. The HCGA may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended subsection (C) effective October 12, 1988 (Supp. 88-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-406. Continuation Coverage

Continuation coverage. Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by 29 U.S.C. 1161 et seq. The employer group shall collect the premium from the employee and pay the premium to HCGA.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-407. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective April 30, 1992 (Supp. 92-2). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Section repealed by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-408. Contract Compliance Sanction Alternative
The Director may impose a sanction or penalty upon a HCG plan or employer group that violates any provision of the rules as specified in contract or the GSA.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Repealed effective July 15, 1997 (Supp. 97-3). New Section made by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. Availability and Accessibility of Services
Availability and accessibility of services. An HCG Plan shall ensure that, within each service area, an adequate number of hospitals, medical care facilities, and service providers are available and reasonably accessible to provide covered services, to members. At a minimum, an HCG Plan shall have:

1. A designated emergency medical service facility, providing care 24 hours-a-day, seven days-a-week. An emergency medical service facility shall be accessible to members in each service area with at least one physician and registered nurse on call or on duty at the facility at all times.
2. An emergency medical service system employing at least one physician, a registered nurse, a physician assistant, or a nurse practitioner, accessible by telephone 24 hours-a-day, seven days-a-week, to:
   a. Provide information to providers who need verification of patient membership and treatment authorization; and
   b. Provide emergency medical services specified in R9-27-101.
3. An emergency medical services call log that contains the following information:
   a. Member's name,
   b. Member's address,
   c. Member's telephone number,
   d. Date of call,
   e. Time of call, and
   f. Instructions given to each member.
4. A written procedure plan for the communication of emergency medical service information to the member's primary care provider and other authorized staff.
5. An appointment system for each of the HCG Plan's service locations. The HCG Plan shall ensure that:
   a. A member with an acute or urgent problem is triaged and provided same-day service when necessary;
   b. A time-specific appointment for routine medically necessary care from the primary care provider is available within three weeks of the member's request and on the same day for emergency care; and
   c. A referral appointment to a specialist is:
      i. On the same day for emergency care,
      ii. Within three days for urgent care, and
      iii. Within 30 days for routine care.
6. Primary care providers that an enrolled member may select or to whom the member may be assigned. An HCG Plan that does not ordinarily include primary care providers shall enter into an affiliation or subcontract with an organization or individual to provide primary care. The HCG Plan shall agree to provide services under the primary care provider's guidance and direction. The primary care provider is responsible for:
   a. Supervising, coordinating, and providing initial and primary care to members;
   b. Initiating referrals for specialty care; and
   c. Maintaining continuity of member care.
7. Primary care physicians and specialists providing inpatient services to a member shall have staff privileges in a minimum of one general acute care hospital under subcontract with the contracting health plan, within or near the service area of the HCG Plan.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-502. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective October 12, 1988 (Supp. 88-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Section repealed by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-503. Marketing and Discrimination
HCGA marketing representatives shall not engage in any marketing or other pre-enrollment practices that discriminate against an applicant or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-504. Approval of Advertisements and Marketing Material

A. Submission of marketing material. The HCG Plan shall submit proposed marketing strategies and marketing material in writing to the HCGA for review and approval before distributing the marketing material or implementing any marketing activity.

B. Review of marketing material. The HCGA shall review and approve or disapprove all proposed marketing material and strategies. The HCGA shall notify the HCG Plan in writing of the approval or disapproval of the proposed marketing material and marketing strategies. The notification shall include a statement of objections and recommendations.

C. Drafts. To minimize the expense of revising marketing material or other copy, an HCG Plan may submit the material in draft form subject to final approval.

D. Submission and maintenance of final copies. An HCG Plan shall submit two copies of the proof or final approved copy of material to the HCGA, which shall maintain the proof or copy for five years.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-505. Member Records and Systems
Member record. Each HCG Plan shall maintain a member service record for each member that contains encounter data, grievances, complaints, and service information.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-506. Fraud or Abuse
Suspected fraud or abuse. All HCG Plans, providers, and noncontracting providers shall advise the HCGA immediately in writing of suspected fraud or abuse.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-507. Release of Safeguarded Information

A. Information to be safeguarded concerning an applicant or member of the HCG program includes:
1. Name, address, and social security number;
2. Evaluation of personal information; and
3. Medical data and services including diagnosis and history of disease or disability.

B. Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, utilization data, and other information that does not identify an individual applicant or member.

C. Safeguarded information concerning a member or applicant shall be disclosed only to:
1. The member or applicant, or, in the case of a minor, the parent, custodial relative, or guardian;
2. Individuals authorized by the member or applicant; and
3. Persons or agencies for official purposes.
4. Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E), and (F).

D. A member or authorized representative may view the member's medical record after written notification to the provider and at a reasonable time and place.

E. Release to individuals authorized by the individual concerned. The HCGA or a HCG Plan shall release medical records and any other HCG-related confidential information of a member or applicant to individuals authorized by the member or applicant only under the following conditions:
1. Authorization for release of information must be obtained from the member, applicant, or authorized representative. In the case of a minor, the member's or applicant's parent, custodial relative, or guardian shall submit an authorization for release of information.
2. Authorization used for release of information must be, submitted in writing separate from any other document, and must specify the following:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom the release shall be made;
   c. The period of time for which the authorization is valid, if limited; and
   d. The dated signature of the member, applicant, or authorized representative. In the case of a minor member or applicant, signature of a parent, custodial relative, or guardian is required unless the minor is able to understand the consequences of authorizing and not authorizing.
3. If a grievance or appeal has been filed, the grievant, appellant, or designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of safeguarded information deemed necessary to the contested issue, to any opposing party in the case.

F. Release to persons or agencies for official purposes.
1. Safeguarded information, case records, and medical services information may be disclosed without the consent of the member, to agents or employees of a review committee.
2. For purposes of this Section, "review committee" means an organizational structure within the Plan whose primary purpose is to:
   a. Evaluate and improve the quality of health care;
   b. Review and investigate the conduct of licensed health care providers to determine whether disciplinary action should be imposed; and
   c. Encourage proper and efficient utilization of health care services and facilities.
3. Any member, agent, or employee of a review committee, who in good faith and without malice, furnishes records, information, or assistance related to the duties of the review committee; or, who takes an action or makes a decision or recommendation related to the duties or functions of the review committee shall not be subject to liability for civil damages as a consequence of the action. This does not relieve a person of liability that arises from that person's medical treatment of a patient.
4. Information considered by a review committee related to the duties or functions of the committee, including records of their actions and proceedings, are confidential and are not subject to subpoena or order to produce except:
   a. When otherwise subject to discovery as a patient's medical records.
   b. In proceedings before an appropriate state licensing or certifying agency. If the information is transferred to an appropriate state licensing or certifying agency, the information shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions.
5. A member of a review committee or staff engaged in work for the committee or any other person assisting or furnishing information to the review committee shall not be subpoenaed to testify in a judicial or quasi-judicial proceeding if the subpoena is based solely on review committee activities.

G. Subcontractors are not required to obtain written consent from a member before transmitting the eligible person's or member's medical records to a physician who:
1. Provides a service to the eligible person or member under subcontract with the program contractor,
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
3. Provides a service under the contract.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-508. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Repealed effective July 15, 1997 (Supp. 97-3).

R9-27-509. Information to Enrolled Members

A. Member handbook. Each HCG Plan shall produce and distribute a printed member handbook to each enrolled member by the effective date of coverage. The member handbook shall include the following:
1. A description of all available services and an explanation of any service limitation, and exclusions from coverage, or charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating the HCG Plan shall only be liable for services authorized by a member's primary care provider or the HCG Plan;
3. A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the member, and a description of the selection process, including a statement that informs members they may request another primary care provider, if they are dissatisfied with their selection;
4. Locations, telephone numbers, and procedures for obtaining emergency health services;
5. Explanation of the procedure for obtaining emergency health services outside the HCG Plan's service area;
6. Causes for which a member may lose coverage;
7. A description of the grievance and request for hearing procedures;
8. Copayment, coinsurance, and deductible schedules;
9. Information on obtaining health services and on the maintenance of personal and family health;
10. Information regarding emergency and medically necessary transportation offered by the HCG Plan; and
11. Other information necessary to use the program.

B. Notification of changes in services. Each HCG Plan shall prepare and distribute to members a printed member handbook insert describing any changes that the HCG Plan proposes to make in services provided within the HCG Plan's service areas. The insert shall be distributed to all affected members and dependents at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-510. Discrimination Prohibition

A. Discrimination. The HCGA or a HCG Plan shall not discriminate against an applicant or a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental disability in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, regulations promulgated under the Act, or as otherwise provided by law or regulation. For the purpose of providing covered services under contract under A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, color, religion, ancestry, marital status, age, sex, national origin, sexual preference, or physical or mental disability includes the following:
1. Denying a member any covered service or availability of a facility for any reason except provided under R9-27-202 or for a pre-existing condition as described in R9-27-210;
2. Providing a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other HCG members under contract, except when medically indicated;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a member's enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental disability of the member to be served.

B. Provision of covered services. An HCG Plan shall take affirmative action to ensure that a member is provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except when medically indicated.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended subsection (A), paragraph (1), effective October 12, 1988 (Supp. 88-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-511. Equal Opportunity

Equal opportunity requirements. An HCG Plan shall comply with the following equal opportunity employment requirements:
1. All solicitations or advertisements placed by or on behalf of an HCG Plan shall state that it is an equal opportunity employer.
2. An HCG Plan shall send a notice prepared by the HCGA to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding. The notice shall advise the labor union or workers' representative of the HCG Plan's commitment as an equal opportunity employer and shall be posted in conspicuous places available to employees and applicants for employment.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-512. Periodic Reports and Information

A. Contract performance. Upon request by the HCGA, each HCG Plan shall furnish to the HCGA information from its records relating to contract performance.

B. Separation of records. Each HCG Plan shall maintain separate records to identify all HCG-related transactions.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-513. Medical Audits

A. Conducting a medical audit. HCGA shall conduct a medical audit of each HCG Plan at least once every 12 months. Unless HCGA determines that advance notice will render a medical review less useful, the HCGA shall notify the HCG Plan no later than three weeks in advance of the date of an onsite medical review. HCGA may conduct, without prior notice, an inspection of the HCG Plan facility or perform other elements of a medical review, either in conjunction with the medical audit or as part of an unannounced inspection program.

B. Procedure for medical audit. As part of the medical audit, the HCGA may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with:
   a. Members;
   b. Physicians and other health care practitioners;
   c. Members of the HCG Plan's administrative staff including its principal management persons; and
2. Examine records, books, reports, and papers of the HCG Plan, any management company of the HCG Plan, and all providers or subcontractors providing health care and other services to the HCG Plan. The examination may include:
   a. Minutes of medical staff meetings,
   b. Peer review and quality-of-care review records,
   c. Duty rosters of medical personnel,
   d. Appointment records,
   e. Written procedures for the internal operation of the HCG Plan,
   f. Contracts,
   g. Correspondence with members and providers of health care services and other services to the HCG Plan, and
   h. Additional documentation deemed necessary by the HCGA to review the quality of medical care.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-514. HCG Plan's Internal Quality Management and Utilization Review System

A. Quality management and utilization review. An HCG Plan shall comply with the following quality management and utilization review requirements:

1. Annually prepare and submit to HCGA for review and approval a written quality management plan that includes utilization review. The quality management plan must be designed and implemented with actions to promote the provision of quality health care services.
2. Design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services, and costs.
3. Medical records and systems:
   a. Ensure that a member's medical records are maintained by the primary care provider, and include a record of all medical services received by the member from the HCG Plan and its subcontracting and noncontracting providers.
   b. Ensure that medical records are maintained in a manner that:
      i. Conforms to professional medical standards and practices,
      ii. Permits professional medical review and medical audit processes, and
      iii. Facilitates a system for follow-up treatment.
4. Develop and implement a program of utilization review methods for hospitals that, at a minimum, includes:
   a. Prior authorization of nonemergency hospital admissions,
   b. Concurrent review of inpatient stays, and
   c. Retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or unreasonably.

B. Evaluation of utilization control system. The HCG Plan's utilization control system is subject to evaluation by the HCGA to determine cost effectiveness, and to measure whether quality management and utilization review methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. An HCG Plan may subcontract with an organization or entity designed to conduct activities regarding prior authorization, concurrent review, retrospective review, or any combination of these activities. A subcontract to conduct quality management or utilization review activities is subject to prior approval by the HCGA.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-515. Continuity of Care

Requirements for continuity of care. An HCG Plan shall establish and maintain a system to ensure continuity of care that includes:

1. Referral of members needing specialty health care services,
2. Monitoring of members with chronic medical conditions,
3. Providing hospital discharge planning and coordination including post-discharge care, and
4. Monitoring the operation of the system through professional review activities.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-516. Financial Resources

A. Adequate reserves. An HCG Plan shall demonstrate to the HCGA that it has adequate financial reserves, administrative abilities, and soundness of program design to carry out its contractual obligations.

B. Contract provisions. Contract provisions required by the HCGA may include:

1. Maintenance of deposits,
2. Performance bonds,
3. Financial reserves, or
4. Other financial security.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4).

Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

ARTICLE 6. REPEALED

Article 6, consisting of Section R9-27-601, repealed by final rulemaking at 10 A.A.R. 817, effective April 3, 2004. The subject matter of Article 6 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-27-601. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Section repealed; new Section adopted effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 817, effective April 3, 2004 (Supp. 04-1).

R9-27-602. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Repealed effective July 15, 1997 (Supp. 97-3).

R9-27-603. Repealed

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Repealed effective July 15, 1997 (Supp. 97-3).

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. HCGA Liability; Payments to HCG Plans

A. Liability for covered services. The HCGA is not liable for the provision of covered services or the completion of a plan of treatment for any member.

B. Liability for subcontracts.
1. The HCGA is not liable for subcontracts that the HCG Plan executes for the provision of:
   a. Administrative or management services,
   b. Medical services,
   c. Covered health care services, or
   d. For any other purpose.
2. Each HCG Plan shall indemnify and hold the HCGA harmless from:
   a. Any and all liability arising from the HCG Plan's subcontracts,
   b. All judgment and injunctive costs of defense of any litigation for liability,
   c. Satisfy any judgment entered against the HCGA arising from an HCG Plan subcontract.
3. All deposits, bonds, reserves, and security posted under R9-27-516 are forfeited to the HCGA to satisfy any obligations of this Section.

C. Payments. All payments to an HCG Plan shall be made under the terms and conditions of the contract executed between the HCG Plan and HCGA as specified in this Article.

D. Premium. Premium payments, less HCGA administrative charges and reinsurance fees, shall be paid monthly to an HCG Plan that has either posted a performance bond or has otherwise provided sufficient security to the HCGA.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-702. Prohibition Against Charges to Members

Prohibition against charges to members. An HCG Plan, subcontractor, or noncontracting provider reimbursed by an HCG Plan shall not charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment, coinsurance, and deductible. This prohibition shall not apply if the HCGA determines that a member willfully withheld information pertaining to the member's enrollment in an HCG Plan. An HCG Plan shall have the right to recover from a member that portion of payment made by a third party to a member when the payment duplicates HCG benefits and has not been assigned to the HCG Plan.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-703. Payments by HCG Plans

A. Payment for covered services. An HCG Plan shall pay the provider for all covered services rendered to the HCG Plan's member if the services were arranged by the HCG Plan's agent or employee, subcontracting provider, or other individual acting on behalf of the HCG Plan.

B. Payment for medically necessary outpatient services. An HCG Plan shall reimburse a subcontracting provider or noncontracting provider for covered health care services provided to the HCG Plan member. Reimbursement shall be made within the time period specified by contract between an HCG Plan and a subcontracting provider or noncontracting provider or within 60 days of receipt of a clean claim, if a time period is not specified.

C. Payment for in-state inpatient and outpatient hospital services including emergency services.
1. An HCG Plan shall reimburse an in-state subcontracting provider for the provision of inpatient or outpatient hospital services, including emergency services specified in R9-27-209, at the subcontracted rate.
2. An HCG Plan shall reimburse an in-state noncontracting provider for the provision of inpatient or outpatient hospital services, including emergency services specified in R9-27-209, according to the reimbursement methodology stated in A.R.S. § 36-2903.01(J).

D. Payment for emergency services. An HCG Plan shall pay for all emergency care services rendered to the HCG Plan member by a noncontracting provider if the services:
1. Conform to the definition of emergency medical services in Article 1 and Article 2 of these rules; and
2. Conform to the notification requirements in Article 2 of these rules.

E. Payment for out-of-state inpatient and outpatient hospital services. An HCG Plan shall reimburse an out-of-state subcontracting provider at the subcontracted rate. An HCG Plan shall reimburse an out-of-state noncontracting provider for the provision of inpatient and outpatient hospital services at the lower of negotiated discounted rates or 80% of billed charges.

F. Payment for emergency ambulance services. An HCG Plan shall reimburse an out-of-state subcontracting provider at the subcontracted rate. An HCG Plan shall reimburse a noncontracting provider for emergency ambulance services at the lower of negotiated discounted rates or 80% of the billed charges.

G. Nonpayment of a claim. In the absence of a contract with an HCG Plan, an HCG Plan is not required to pay a claim for a covered service that is submitted more than six months after

the date of the service or that is submitted as a clean claim more than 12 months after the date of service.

H. Notice of a denied claim. An HCG Plan shall provide written notice to a provider whose claim is denied or reduced by an HCG Plan within 30 days of adjudication of the claim. This notice shall include a statement describing the provider's right to:
1. Grieve the HCG Plan's rejection or reduction of the claim; and
2. Submit a grievance to the HCGA, or its designee under 9 A.A.C. 27, Article 6.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3).

R9-27-704. HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members

A. Liability to noncontracting hospitals. An HCG Plan is liable for reimbursement for a member's emergency medical condition:
1. Until the time the member's condition is stabilized and the member is transferable to a subcontractor; or
2. Until the member is discharged post-stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.

B. Liability when transfer of member is not possible. Subject to the provisions of subsection (A), if a member cannot be transferred for post-stabilization services to a facility that has a subcontract with the HCG Plan of record, the HCG Plan shall pay the provider for all appropriately documented medically necessary treatment provided the member before the date of discharge or transfer. The reimbursement is the lower of a negotiated discounted rate or prospective tiered-per-diem rate.

C. Member refusal of transfer. If a member refuses transfer from a noncontracting hospital to a hospital affiliated with the member's HCG Plan, neither the HCGA nor the HCG Plan shall be liable for any costs incurred subsequent to the date of refusal if:
1. After consultation with the member's HCG Plan, the member continues to refuse the transfer; and
2. The member is provided and signs a written statement of liability, before the date of discharge or transfer informing the member of the medical impact and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-705. Copayments

A. Payment of copayment. A member shall be required to pay a copayment directly to a provider at the time covered services are rendered.

B. Determination of copayment. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:
1. The impact the amount of the copayment will have on the population served, and
2. The copayment amount charged by other group health plans or health insurance carriers for particular services.

C. Copayment provisions. The HCGA shall include the copayment provisions in the contract with an HCG Plan and the employer group.

D. Schedule of copayments. HCGA shall provide a schedule of the copayments to members at the time of enrollment.

Historical Note
Adopted effective October 1, 1987 (Supp. 87-4). Section repealed; new Section adopted effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-706. Payments by Employer Groups

An employer group shall submit the monthly premium payment to the HCGA by the first day of the month prior to the month of coverage. The monthly premium payment is delinquent if received or postmarked after the 25th day of the month prior to the month of coverage and subject to R9-27-405 and the GSA.
1. An employer group shall pay the monthly premium to HCGA with sufficient funds in the form of a:
   a. Cashier's check,
   b. Personal check,
   c. Money order,
   d. Automatic debit from a checking or savings account, or
   e. Other means approved by the HCGA.
2. An employer group whose payment is returned for nonsufficient funds shall pay the monthly premium in the form of a:
   a. Cashier's check,
   b. Money order, or
   c. Other means approved by the HCGA.

Historical Note
New Section made by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-707. Reinsurance

A. Provision of reinsurance. The HCGA may elect to provide reinsurance through a private reinsurer.

B. Insured entity. For purposes of the HCGA's reinsurance program, the insured entity shall be the HCG Plan with which the HCGA contracts.
1. The HCGA shall deduct a specified amount per member, per month, from the employer group's monthly premium to cover the cost of the reinsurance contract.
2. The HCG Plan shall comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA.

Historical Note
New Section made by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).

R9-27-708. Payments to Providers

The Administration or a contractor shall pay providers under A.A.C. R9-22-714.

Historical Note
New Section made by final rulemaking at 9 A.A.R. 3806, effective October 4, 2003 (Supp. 03-3).

ARTICLE 8. COORDINATION OF BENEFITS

Editor's Note: The entry in the Historical Note for Supp. 00-3 for the following Section was mistakenly not added in Supp. 00-3. It is added in Supp. 01-2.

R9-27-801. Priority of Benefit Payment

A. HCG Plans shall coordinate all third-party benefits. Services provided under the HCG Plan are not intended to duplicate other benefits available to a member.

B. Order of payment for members with other insurance. If a member has other coverage, payment for services shall occur in the following order:

1. A policy, plan, or program that has no coordination of benefits provision or nonduplication provision shall make payment first.
2. If a member is covered by another plan or policy that coordinates benefits:
   a. The plan that provides or authorizes the service shall make payment first.
   b. A plan, other than a prepaid plan, that covers a person as an employee shall make payment before a plan that covers the person as a dependent.
3. If coverage is provided to a dependent child and both parents have family coverage:
   a. The plan of the employee whose birthday occurs first in the calendar year shall be primary, and the plan of the employee whose birthday occurs last in the calendar year shall be secondary.
   b. If both employees have the same birthday, the plan of the employee, that has been in force longer shall pay first.
   c. If one of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.
4. If coverage is provided to a dependent child of divorced employees, the order of benefit shall be:
   a. The plan of the employee with custody of the child shall pay first;
   b. The plan of the spouse of the employee with custody of the child shall pay second; and
   c. The plan of the employee not having custody of the child shall pay last.

C. Primary payors. An HCG Plan shall not be primary payers for claims involving workers' compensation, automobile insurance, or homeowner's insurance.

D. Lien and subrogation rights. An HCG Plan shall have lien and subrogation rights as those held by health care services organizations licensed under A.R.S. Title 20, Chapter 4, Article 9.

Historical Note

Adopted effective October 1, 1987 (Supp. 87-4). Amended effective July 15, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 3340, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 8 A.A.R. 5154, effective January 1, 2003 (Supp. 02-4).